ITEMIZED STATEMENT OF COMPENSATION
(DWC-50)

General Instructions:

- Completed by: Claim Administrator.
- Time Frame: Within 60 days after the discontinuance or suspension of compensation payments.
- Distribution: Original to Department of Labor and Training (DLT). Copy to the employee and his or her attorney and also to the employer, if filed by the insurer.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:
- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.

2. Claim Information:
- *Employer:* Name of company where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).
- *Date of Death:* Conditional, if employee died – Check appropriate box as to whether death was work-related or not.

3. Incident Only:
- Check this box if no payments were made on the claim. Complete Section 8 and return to DLT only.

4. Nonpayment of Weekly Indemnity Only:
- *Medical Only:* Check if medical payment(s) were made on the claim but NO weekly indemnity.
- *Federal Jurisdiction:* Check if claim fell under Federal Jurisdiction for weekly indemnity.
- *Salary Continuation:* Check if full salary was continued for employee.
- *Denied:* Check if claim was denied by Claim Administrator.
- *Death:* Check if death was work-related and there were no dependents.
- *Other:* Use **only if** none of the above apply; for example, if the claim is under another state's jurisdiction and had been sent to RI by mistake.

5. Diagnosis:
- *Primary Written Diagnosis:* Enter the primary written diagnosis supplied by medical provider.
- *ICD Code:* International (Statistical) Classification of Diseases (and Related Health Problems) code should be supplied by medical provider.
- *Secondary Written Diagnosis:* Enter the secondary written diagnosis, if any, provided by medical provider.
- *ICD Code: International* (Statistical) *Classification of Diseases* (and Related Health Problems) code should be supplied by medical provider.

6.Payment Information: For each and every item where payment was made, enter the total amount paid. In the case of Subrogation, check Yes or No as to whether or not the claim was subrogated.
- *Date of First Indemnity Payment:* Enter the date the first indemnity payment was made.

7. Return to Employment: Please complete all requested information.

8. *This Report was Prepared by:* **PRINT ALL INFORMATION**
- *Name:* Print full name of person who filled out the form (report preparer).
- *RI Adjuster License Number:* Enter RI Adjuster License Number as issued by the RI Department of Business Regulation. Note: DO NOT ENTER SSN – Request another number from DBR.
- *Company Name:* Name of the company where the report preparer is employed.
- *Address (including city, state, zip):* Mailing address of the company where the report preparer is employed.
- *Phone/Ext/Email:* Phone number and extension (if necessary) and email address of the report preparer.
- *Signature/Date*: Signature of the person who filled out the form and the date that the form was prepared.